Institute for Advanced Development Studies

inesad

12/2011

TOWARDS UNIVERSALISM? THE OBSTRUCTED PROCESS OF HEALTHCARE REFORM IN BOLIVIA

By

Sebastian Sirén

Development Research Working Paper Series

12/2011

December 2011

TOWARDS UNIVERSALISM?

THE OBSTRUCTED PROCESS OF HEALTHCARE REFORM IN BOLIVIA

by
Sebastian Sirén

(December 2011)

Abstract

In this article a process-tracing approach is used to explore how different factors have contributed to the development of healthcare policy in Bolivia, in light of the current proposal to introduce a unified public healthcare system. The main findings are that although international relations and state bureaucrats have been crucial to the process of formulating policies, the introduction of comprehensive reform will depend on the ability of groups who currently lack access to the healthcare system to form progressive coalitions promoting universalism, as well as the ability of those who benefit from the current arrangements to maintain the status quo. The ability to introduce comprehensive reforms is thus connected to the ongoing processes of decentralisation and democratisation of political decision-making in Bolivia. Although state-corporative welfare state institutions have been shown to be difficult to transform, low coverage levels in such systems combined with a process of increasing political inclusion of previously marginalised groups poses serious challenges to the status quo as the social aspect of citizenship is brought up on the agenda. In order to achieve universal coverage of the healthcare system, however, basic social rights of all citizens must be institutionalised at the same time as the scope and quality of services must be secured in order to avoid segmentation and to encourage the financial participation of the formal and middle income sectors.

Keywords: Bolivia, health care, social policy, institutional change, power resources, policy diffusion.

*Contact: sebastian.siren@sofi.su.se. This article is a re-edited version of a D-level thesis presented at the Department of Government at Uppsala University in September 2011. The author would like to thank the Minor Field Study committee at the Department of Government at Uppsala University and the Swedish International Development Cooperation Agency (SIDA) for the grant that made the field study in Bolivia possible. Joakim Palme served as thesis advisor and deserves special thanks for his support. As well, my greatest appreciation goes out to all those who participated in interviews during the field study.

Index

Abbreviations

ALBA-TCP	La Alianza Bolivariana para los Pueblos de Nuestra América - Tratado de Comercio de los Pueblos (Bolivarian Aliance for the Peoples of Our America –
the	Peoples Trade Agreemet)
ALAMES	Asociación Latinoamericana de Medicina Social (Latin American Association for Social Medicine)
COB	Central Obrera Boliviana (Bolivian Workers' Confederation)
HIPC	Heavily Indebted Poor Countries
IADB	Inter-American Development Bank
IDH	Impuesto Directo a Hidrocarburos (Direct Tax on Hdrocarbons)
IFI	International Financial Institution
IMF	International Monetary Fund
INASES	Instituto Nacional de Seguridad Social (National Social Insurance Institute)
IMF	International Monetary Fund
IO	International Organisation
MDRI	Multilateral Dept Relief Initiative
MSD	Ministerio de Salud y Deportes
OISS	Organisación Iberoamericana de Seguridad Social (Ibero-American Social Security Organisation)
PRA	Power Resource Approach
SAFCI	Salud Familiar, Comunitario Intercultural (Family, Community and Intercultural Health)
SIMRA	Sindicato Médico y Ramas Afines (Union of Doctors and Related Professions)
SUMI	Seguro Universal Materno Infantil (Universal Mother and Child Insurance)
SUS	Sistema Único de Salud (Unified Healthcare System)
WHO	World Health Organisation
UNICEF	United Nations Children's Fund
MAS-IPSP	Movimiento al Socialismo – Instrumento Politico para la Soberanía de los
Pueblos	(Movement Towards Socialism – Political Instrument for the Soverignity of the Peoples)
WB	World Bank

1. Introduction

Latin America pioneered the development of social security, with the first countries introducing social health insurance during the 1910s and 1920s. Although social security has spread across the continent, the programs only cover an estimate of 45 percent of the population, leaving informal workers and the great majority of the rural population excluded from access. [1] The Bolivian health care system presents some of the general features of social policy in the region, including a dual labour market, segmented and regressive social policies and staggering levels of inequality. The healthcare system retains these features and has been unable to tackle the precarious health situation of the population, despite incremental reforms introduced during the last decades. The country shows one of the highest levels of informality in the labour market in the continent, and access to health care remains highly dependent on ability to pay for services. Confronted with this situation the Bolivian government has launched a proposal for a comprehensive reform of the health care system, envisioning universal access to a unified system by expanding the public sector. This case is used to asses some of the recurrent claims in welfare state research on how welfare state institutions emerge and evolve over time, in order to improve our understanding of how social citizenship rights become institutionalised.

The interest of this thesis is to investigate what has brought the Bolivian government to the brink of enacting a reform, making health care a claim-right towards the government. In order to do this, this article offers an account of the historical evolution of the right to health care in Bolivia and seeks to connect the evolution of new institutions to socio-political factors promoting or precluding change. The purpose of this exercise is to contribute to the knowledge about the processes shaping social policy by relating the Bolivian case to the growing literature on welfare state development and institutional change. By doing so the case study of Bolivian healthcare reform serves to illuminate the benefits and setbacks of theoretical explanations about welfare state development which have been recurrent in social science research. It also contributes to our understanding how welfare state institutions develop in a context characterised by labour market informality and segmented social policy, common features of the context in many developing countries where social policy institutions are being reformed.

The main question seeking its answer throughout this thesis is accordingly:

[1] Mesa-Lago (2009) p. vi.

The thesis begins by introducing the Latin American social policy context and highlighting some of the most important concepts which impinge on our understanding of healthcare reform in Bolivia and Latin America. In the following chapter, the theoretical framework of the study is introduced, by presenting theories derived from research on welfare states, institutional change and policy diffusion. The review of the theoretical literature includes a number of hypotheses to be assessed throughout the case study. This chapter is then rounded of by a discussion of some of the previous research on healthcare and social policy reform in relation to the approach for this study. In the third chapter, the methodological considerations made when designing the study are discussed, introducing the study's approach to historical explanation. After this the case study is presented, were the theoretical frameworks discussed earlier is applied to data on the evolution and contemporary reform of the Bolivian healthcare system in light of a changing political and socio-economic context. The thesis is then rounded of with a discussion around the most important findings from the case study and their implications for our understanding of how welfare state institutions evolve over time.

2 Social policy in Latin America: Universalism, targeting and social insurance

In contrast to many other developing regions Latin America has a long history of formal welfare institutions. The development of modern social security institutions accelerated from the 1920's and onwards, evolving in a variety of ways reflecting general patterns of stratification in each society.[2] The main strategy for achieving universal social protection in Latin America during the mid twentieth century has been through state-corporatist institutions, with social insurance granting defined benefits to workers in the formal sector. In reality, these systems created a "stratified universalism", mainly protecting population groups linked to the state-building and industrialisation projects, while institutionalising patterns of exclusion and giving the welfare systems a regressive character.[3]

Severe economic crisis and subsequent structural adjustments during the last two decades of the twentieth century, the latter encompassing trade liberalisation, macro-economic stabilisation and privatisation together with labour and capital market liberalisation turned the

[2] Mesa-Lago (1978) p. 5, 17ff.
[3] Mkandawire (2005) p. 4.

Latin American economies away from income substitution industrialisation towards export oriented growth strategies. With the decline of industrialisation and a process of democratisation which did not yield sufficient reductions in the level of poverty, new forms of social protection emerged. With international financial institutions such as the IMF framing welfare programs as distortionist, many of these institutions were reformed, giving them an increasingly residual character.[4] The difficult extension of social insurance, the stratified character of social services and the high levels of poverty combined with a decline of organised labour as promoters of reform has led to a focus on targeted social assistance.[5] In the healthcare sector the reforms in the region have resulted in an expansion of private insurance and care provision, with greater autonomy for private providers and more elements of competition, with private and social insurance gaining ground from the public sub-system.[6]

With the implementation of new social policies in developing countries during the last two decades, there has been a lively debate on the design of social programs.[7] A targeted approach to social protection, promoted by many IFIs, have been claimed to generate higher levels of redistribution by making effective use of public resources and by channelling these to those in greatest need of assistance.[8] However, universalistic policies have in turn been noticed to generate even higher levels of overall redistribution due to their cross-class characteristics, making higher revenues available for redistribution.[9] Recent trends on a global level point towards a drift away from a strict application of targeting towards more universal programs,[10] but often retaining a focus on the poorest segments of the population.[11]

However, this renewed interest for universalist policies also highlights the different meanings that have been assigned to the word.[12] The main source of confusion emerges from the use of the word to describe the aim, effects as well as the characteristics of social policy. Here, universalism will be referred to as the institutional characteristics of specific social policy programs with universal access to a comprehensive set of services, irrespective of labour market status or ability to pay.[13]

The Bolivian proposition for a Unified Health System (SUS) embraces this comprehensive understanding of universalism and proposes a reform which attempts to break

[4] Barrientos (2004) p. 141.
[5] Barrientos (2010) p. 10.
[6] Barrientos (2004) p. 142ff, See also Weyland (2006).
[7] See Mkandawire (2005), Barros & Carvalho (2004).
[8] Barros & Carvalho (2004).
[9] Korpi & Palme (1998), Mkadawire (2005) p. 13.
[10] Deacon (2005).
[11] Filgueira et al (2006).
[12] See Bergh (2004).
[13] Cf. Rothstein (2001) p. 218.

with the segmented character of the healthcare system.[14] The proposition suggests that the public health care system on all levels, together with the providers of traditional medicine is to constitute the Unified Healthcare System. The existing social health insurance funds are to be incorporated into the system through special agreements. All funds which are currently being directed to health care within the public system at all levels, including departmental and municipal funds, are to be collected in a national Unified Health Fund destined to finance the new health care system. The government is then to allocate additional resources to this fund in order to guarantee a budget of 70 USD per person not insured by the mandatory social insurance system. These resources are then to be distributed to specific departmental, municipal and indigenous community health accounts, according to population size, level of poverty, geographical coverage levels and the level of provision. The proposition recognises the same organisational levels as the current healthcare system; local, municipal, departmental and national, while introducing the indigenous communities as an additional level. The access to the SUS is to be universal, abolishing out-of-pocket payments, and will thus replace the current public insurance schemes covering women in fertile age, children under five years and the elderly above 65 years.

The Unified Health System thus signifies a break with the previously segmented national health system where a social insurance, public, private and traditional medicine sub systems each provided healthcare to separate population groups depending on labour market status and ability to pay, with scarce coordination between them. The new system envisions universal accesses and emphasises public provision and funding from general taxation, collected at different levels, in contrast to the previous domination by social insurance and out-of-pocket payments as primary funding mechanism.[15] The question under study is thus: how does such a change come about?

3 Theoretical framework

The following section presents a framework for analysing social policy change; taking the interplay between actors, institutions and ideas into account, drawing up five hypotheses based on the theoretical perspectives presented.

[14] The proposal for a "Sistema Único de Salud" has been promoted by the Ministry of Health and was recently formulated as a proposition to the executive and the congress. See Ministerio de Salud y Deportes (2011a).
[15] For a diagnostic of the Bolivian healthcare system, se for example Picado & Durán (2007) or Prieto & Cid (2010).

3.1 Power resource approach

Many scholars have emphasised that the way in which institutions are created and function reflects the distribution of power in society, with a change in power distribution leading to institutional change. [16] The power resource approach (PRA) offers a way to conceptualise these conflicts and thereby linking them to the development and divergence between different welfare regimes or institutional models.[17]

PRA conceptualises welfare state institutions in terms of "policies to affect outcomes of, and conditions for, distributive processes in the sphere of markets so as to decrease inequality and/or poverty".[18] Employment relations are seen as the primary mechanism shaping the processes of socio-economic stratification and employers and employees are therefore seen as the main antagonists in these conflicts over distribution. The important distinction between these two groups lay in the types of assents they employ in labour markets, with employers engaging their economic assets while employees primarily rely on their labour power. The characteristics of economic assets, making them transferable between individuals, tend to concentrate these resources while labour power remain disperse. The efficacy of labour power might however be significantly enhance via collective action. These characteristics of labour markets creates a *logic of the situation* were holders of concentrated economic assets tend to be more favourable towards market solutions where their assets are most efficacious, while employees are more dependent on collective action to enhance the efficacy of their resources, thus favouring political and non-market solutions to a greater extent.[19]

Thus Navarro states that the principle of universality has been a paramount importance to the working class, assuring the principle of class solidarity, and that working class organisations have historically opposed both corporatism and targeting as ways to structure healthcare policy.[20] However, differences among employees with regards to their positions on the labour market might differentiate their positions towards the welfare state institutions.[21]

Bolivia is one of the most unequal countries in the most unequal region of the world, with political conflicts arising over the distribution of society's resources. The PRA thus inform us of a possible way of explaining the emergence of a unified healthcare system in

[16] Korpi (1983), Mahoney & Thelen (2010) p. 8, Knight (1992) p. 84ff, 210.
[17] Kori & Palme (1998), Esping-Andresen (1990).
[18] Kori & Palme (2003) p. 428.
[19] Korpi (2006) p. 172.
[20] Navarro (1989) p.
[21] Korpi & Palme (2003) p. 427.

Bolivia by focusing on the struggle between organised interests representing different socio-economic groups.

Hypothesis 1: The "logic of the situation" makes those with limited resources to cope with life-course risks particularly disposed to promote universal welfare state institutions through collective action.

3.2 State centred approach

Within PRA the state is primarily seen as an arena were the conflicts between socio-economic groups are played out. In response to these and other instrumentalist and functionalist views on the state, scholars came to emphasise the importance of looking at the state as a cause of political outcomes.[22] The state is seen to matter in two ways; first, states may be sites of "autonomous political action", with bureaucrats pursuing their own and their organisations' interests. Secondly, states matter because they shape the meanings and methods of politics for those groups engaged in the struggle over new policies.[23] The ability of states to pursue their agendas is moreover dependent on their capacity to formulate and implement new policies.[24]

State authorities have by some scholars been seen to pursue their goals according to organisational interest, especially in authoritarian-bureaucratic states, with a tendency to expand public expenditure as far as their financial and human capacities allow.[25] However, states may also pursue goals that are beyond their reach, with ambiguous and unintended outcomes as the result. Apart from administrative-military control over its' territory; financial resources as well as loyal and skilled officials are often deemed important for the state's capacity to pursue its' goals.[26]

As for the impact of political institutions, the existence of strong veto points for those seeking to preserve the status quo might block processes of change. In work on the welfare state, federalism, bicameralism and presidentialism have been noted to constitute potentially important institutional veto points, which might be used to block or slow down welfare state reform by dispersion of policy making authority.[27] But as scholars focusing on gradual processes of institutional change has noted, the existence of strong veto-points might also make advocates of change adopt more covert strategies in order to obtain their goals.[28]

[22] Skocpol (1985) p 9.
[23] Orloff & Skocpol (1984) p 730f.
[24] Skocpol (1985) p 9.
[25] Skocpol & Amenta (1986) p. 149f.
[26] Skocpol (1985) p 16.
[27] Bonoli (2001)Immergut (1992).
[28] Mahoney & Thelen (2010) p. 18ff.

The political struggles over the redistribution of recourses and political control in Bolivia, can accordingly be analysed in the light of the interplay between government action and interest group formation. Moreover, the claim that the state can be seen as an autonomous actor in the process of policy formulation will be assessed throughout the case study as it represents a point of divergence with PRA and other society-oriented approaches.

Hypothesis 2: State bureaucrats will pursue autonomous policy goals for personal or organisational benefit.
Hypothesis 3: The existence of strong institutional veto-points will make a comprehensive reform less likely.

3.3 Ideas and policy diffusion

Recently, there are signs of an increasing concern with the unfair characteristic of the current process of globalisation, and a renewed interest in the social dimension of development seems to be emerging on a global level, allowing for higher levels of public spending and state intervention.[29] In light of these trends the Bolivian case might be illustrative of the way in which the diffusion of policy ideas on a global level is tied to the struggle over the distribution of resources in society.

In studies on the development of welfare state institutions in advance-capitalist societies, domestic political and structural factors prevail. As well, scholars interested in institutional change have mainly studied the effects of the existing institutions without paying more explicit attention to the generation of alternatives.[30] The global level is highlighted in this thesis as a source of alternative ideas and as an arena for struggles over the design of social policies. The global level might be particularly important in developing countries like Bolivia, dependent on foreign debt and external funding for the promotion of costly public policy.

The processes of policy diffusion are of various kinds. Dobbin et al review the mechanism by which public policies spread across nations and come across four main currents.[31] Constructivists tend to emphasise s*ocial emulation* through the example set by an influential policy leader, theoretisation by expert groups or contingent arguments from specialists as the main mechanisms diffusing policies. Others focus on *coercion* brought about by conditionality, policy leadership or ideological hegemony.[32] A third current emphasises the role of competition for the convergence of public policy between countries. Finally, some scholars emphasise learning processes which changes policy-makers beliefs about causes and effects.

[29] Rittich (2007) p. 108.
[30] Weyland (2007) p. 232, cf. Clemens & Cook (1999) p .459f.
[31] Dobbins et al (2007).
[32] See for example Armanda, Muntaner & Navarro (2001) p. 731.

Kurt Weyland argues that learning processes are in turn structured by cognitive shortcuts used by public decision makers; such as availability, representativeness and anchoring.[33]

Weyland also argues that the adoption of similar health care reforms in Latin America can be understood as results of policy diffusion through a combination of pressures from IFIs and the emergence of new normative appeals.[34] The complexity of issues related to health care means that the outright copying of an entire model or blueprint is unlikely to prevail as the primary mechanism of policy diffusion; rather, it has been the diffusion of general principles which has influenced decision makers in this area, exemplified by the widespread diffusion of the principles of the maxim of "Health for All", codified during the conference in Alma. [35]

Hypothesis 4: The policies adopted will emulate policies pursued by other governments and international organisations.

3.4 Institutional change and path dependency

Researchers studying welfare state institutions has noted how social policies, when implemented, have feedback effects on future policy making.[36] This has resulted in many examples of studies focusing on how the selection of one or another diverging path influences later developments, makes change path dependent.[37] The moments of transition preceding the lock-in of an institutionalised political pattern, when a number of diverging paths are seen as possible outcomes, are typically described as critical junctures, often associated with exogenous chocks.[38] However, this framework is criticised for lacking important theoretical components which would enable it to explain gradual transformation of institutions, and to include endogenous sources of change.[39] In contrast, growing number of theorists studying institutional change have concerned themselves with explaining how transformative processes evolving over time has made retrenchment and privatisation possible in advanced capitalist economies. [40]

---

[33] Weyland (2006) p. 16.
[34] Weyland (2006) p. 180.
[35] Weyland (2006) p. 143.
[36] Korpi & Palme (1998), Esping-Andresen (1990) and Skocpol & Amenta (1986), Weyland (2006) p. 232,.see also Pierson (2004).
[37] Mahoney (2000), Pierson (2000).
[38] Collier & Collier (1991), Pierson (2004) p. 135.
[39] Mahoney & Thelen (2010) p. 5.
[40] For important theoretical contributions see Streek & Thelen (2005), Mahoney & Thelen (2010) and Pierson (2004).

The Bolivian case, however, provides us with an example of increased state intervention, government regulation and public provision of social services, contrary to the tendencies highlighted by studies in advanced capitalist societies. This thesis thus highlights the importance of developing theories capable of explaining how path dependent processes might result in an extension of social rights.

Building on previous research on temporal political processes, the task is seen as identifying the constraint placed on political action by institutions while simultaneously incorporating a dynamic component in the conceptualisation of institutions in order to generate a theoretical framework capable of accounting both for change *and* stability. In order to asses the ambiguous role of institutions, the following hypothesis is added to the study.

Hypothesis 5: Policies introduced at an earlier stage will have significant implications for the subsequent development, resulting in a path dependent political process.

3.5 Previous research and the causes of divergence in healthcare reform

Research on welfare state institutions and their evolution and change over time has been a growing field during several decades. One of the most important dimensions of any welfare state, both in economical terms as well as in terms of impact on the welfare of the population, is the health care system. Researchers have emphasised different causes for the development and reform of these complex institutions. For example, a study by Vicente Navarro shows how the labour movement has been the protagonist in promoting universalism, state control and progressive taxation; thereby enabling the provision of health care services outside of market relations. Accordingly, where labour and its political parties have been most influential, health care systems to a larger extent tend to be universal and publicly managed.[41] Others have rather tended to explain the emergence, and divergence, of healthcare systems by pointing to how existing institutions and historical legacies shape the development of health care policies. James Hacker emphasises the historical and institutional aspects of the development of healthcare systems. The form the developing system takes is, according to this perspective, dependent on "market structures, policy ideas, interest group strategies and public views that have formed in response to previous government policies".[42] Ellen Immergut has in turn shown how political institutions have effects on the development of national health insurance, thus explaining the divergence between countries. She asserts the importance of the mechanisms which transmits social pressures to political-decision makers, focusing on the institutional frame within which

[41] Navarro (1989).
[42] Hacker (1989).

decisions are made.[43] In another study, Collins et al emphasise the importance of contextual factors for understanding the process of decision-making in relation to healthcare reform, with healthcare institutions responding to socio-economic, political, demographical and epidemiological changes.[44]

Throughout the twentieth century most Latin American countries have embarked on some form of reform of the health care sector. There has been a high level of diversity in terms of when reforms where introduced, the character of the reforms and their degree of implementation.[45] Reforms have on many occasions been parallel to the more general structural adjustments introduced in Latin America during the 1980s and 90s, and have often been designed according to the dominant neoliberal ideology with a predominance of financial considerations.[46]

Domestic actors such as health professionals, hospital and social insurance administrators as well as labour unions have generally been opponents of market oriented, efficiency enhancing reforms.[47] These groups have instead, often in coalitions with political parties seeking electoral support by promoting equity enhancing *distributive* reforms, promoted the expansion of public health expenditures. The conflicts of interests among actors have led to a divergence of emphasises in different countries, often as the result of political compromises.[48]

The causes of healthcare reform are complex and the explanations proposed in the research literature are diverse. However, it is seldom claimed that states are to be analysed independently from their socio-economic and cultural contexts. Rather, the importance of policy legacies and political institutions have been incorporated into society-centred and class based explanations.[49] As well, the formation and capacities of classes and interest groups can be analysed as dependent on the structure and activities of the state they seek to influence. Simultaneously, there is a need for greater integration of research focused on interests and institutions with that concerned with the impact of ideas and the importance of alternatives for the outcome of reforms.

How can we understand the formation of coalitions on social policy reform in a developing region such as Latin America? Isabela Mares and Mattew Carnes have elaborated a

[43] Immergut (1993).
[44] Collins et al (1999).
[45] For an overview see Mesa-Lago (2009) p. 155ff.
[46] Mesa-Lago (2009) p. 162, Levcovitz (2006) p. 3.
[47] Homedes & Ugalde (2005) p. 3f.
[48] Mesa-Lago (2009) p. 162, Weyland (2006) p. 168.
[49] Esping-Andersen (1990), Korpi & Palme (2003) p. 431.

theory linking the design of social policy to the de-industrialisation of the economy.[50] De-industrialisation is defined as a process where manufacturing and agriculture are losing in importance to a growing service sector, which to a greater extent than the traditional sectors is characterised by informal working conditions. According to Carnes and Mares, contracted or formal labour has a preference for social policy programs where benefits are linked to contributions, thus securing a higher level of benefits. Accordingly informal labour is assumed to opt for a provision of benefits based on general taxation, granting access to benefits also to non-contributors. In the presence of existing social insurance institutions where entitlements are tied to contributions, a cleavage emerges between insiders concerned with the preservation of their benefits and outsiders seeking to change the design of the existing institutions.[51] The formation of strategic alliances are thus of importance for the political outcomes, with organised formal sector workers as a pivotal group able to form coalitions with low-income groups favouring greater redistribution, or allying themselves with high income earners in opposing redistribution. The possibility of defendants of the status quo to oppose social policy reform will moreover depend on other factors, such as linkages to political parties and the existents of institutional veto-points.[52] Such an approach to the investigation of preference formation and the impact of structural, political and institutional factors on the process of social policy reform seems like a fruitful starting point of further inquiry.

Integrating agency and institutions within the same theoretical framework may significantly alter the expectations that we draw from theory then if each dimension would be studied separately. An important contribution by this thesis will thus be to highlight the relationship between institutions, ideas and interests formation by explicitly account for how our understanding of the interests or ideas underlying policy reform is altered by taking institutions into account.

[50] Carnes & Mares (2010).
[51] This tendency has been duly noted in studies on welfare state reform in Latin America. See for example Barrientos (2004) p. 160.
[52] Mares & Carnes (2009).

4 Method

4.1 Theory development and within-case analysis

There is an ongoing debate over the appropriateness of different methodological approaches as ways to test and develop theories.[53] On the one hand, statistical methods, depending on correlation of variables, have been widely used in social science research and are the basis of many of the works cited earlier in this thesis. On the other hand, focusing on comparison between a small number of cases or even a single case have emerged as a useful strategy in order to identify the casual mechanisms connecting cause and effect.[54]

One can distinguish between different forms of causal processes, of which the simplest is a linear chain of events linked by direct causation. However, most social phenomena are characterised by complex causality where the outcome is the result of the convergence of several conditions or the interactions between different causal factors. When this type of causation is assumed, historical analysis has several advantages as compared to statistical methods. The Bolivian health care reform in this case is analysed as path dependent process, where key decisions and branching points foreclose certain paths of development, making the temporal dimension and interaction effects important for the eventual outcomes.

A theoretically informed historical analysis, and specifically a approach resembling process tracing and systematic process analysis as proposed by Peter A. Hall and Alexander George and Andrew Bennet, is used in this study to map the sequence of events as they unfold, allowing for the identification of path dependent processes and interaction effects. [55] The general procedure of this type of approach is identifying the relevant causal factors and how they operate from theory, make as many observations as possible and thereafter compare these with the predictions made by theory in order to determine which theoretical explanation that best capture the observed pattern.[56] Moreover the study uses within-case analysis to make multiple observations within a case in order to infer causality by paying attention to sequence and using within-case comparison in order to identify the mechanism that transfers the hypnotised effect from one variable to another.[57]

---

[53] Bates et al (2000), Mahoney (2001) and Hall (2003). For a review of the literature see especially Bennett & Elman (2007).
[54] George & Bennet (2005), Mahoney (2001).
[55] George & Bennet (2005) p. 212.
[56] Hall (2003).
[57] George & Bennet (2005), Mahoney (2000).

4.2 Causal mechanisms and context

Causal mechanisms are often confounded with intervening variables and their specification is often reduced to ”simply […] appealing to another correlation of observed variables”.[58] In contrast, Tulia G. Falleti and Julia Lynch suggest that causal mechanisms should be understood as relational concepts telling us how things happen defining them as “portable concepts that explain how and why a hypothesized cause, in a given context, contributes to a particular outcome”.[59] Moreover, they broadly define the context to be taken into account when studying social phenomena as “the relevant aspects of a setting (analytical, temporal, spatial, or institutional) in which a set of initial conditions leads (probabilistically) to an outcome of a defined scope and meaning via a specified causal mechanism or set of causal mechanisms”.[60] This definition leads us to conclude that any causal chain is embedded in a set of social, economic, cultural and political conditions, which influence the trajectory of any given causal process. The elaboration of a coherent narrative makes it possible to contextualise the process under study at any given stage, incorporating the effects of the context on the workings of a causal mechanism.[61]

Taking path dependence into account, institutional change may occur because transitions take place in different domains in an asynchronous manner. A possible way to identify how interactions and encounters among processes in different institutional realms open up the possibility for institutional change is to include a notion of multi-layered contexts.[62] The present case study of Bolivian health care politics is analysed using such a multilayered framework, identifying socioeconomic, political and institutional layers influenced by separate processes, thereby creating frictions which shape the processes of institutional change. The present analysis also pays close attention to the sequencing and timing of events, in order to account for the impact of policy legacies and feedback effects, placing the process of change in a historical perspective.

4.3 Actors and context

The strategies of actors engaging in processes of institutional change are within institutionalist research seen to be dependent on the political context in which this process takes place, as well as the characteristics of the targeted institutions. These characteristics make the presence of

[58] Mahoney (2001) p. 578.
[59] Falleti & Lynch (2009) p. 1147.
[60] Falleti & Lynch (2009) p. 1152.
[61] Büthe (2002) p. 490.
[62] Thelen (1999), Falleti & Lynch (2009) p. 1156-1158.

certain types of change agents more likely in certain contexts, associated with the specific strategy employed by these agents.[63] The setting in which struggles over institutional change takes place also influences which coalitions are formed in defence or opposition to the status quo.[64] For example, when identifying relevant coalitions, insights are drawn on how generative cleavages in society lead up to a transformative process.[65]

An important remark stemming from the theoretical framework presented above is that the interests of actors cannot simply be read of their actions, but must instead be evaluated by referring to the logic of the situation. Because actions might respond to second order preferences and be the result of strategic behaviour, Walter Korpi has suggested a typology of actors based on their role in the expansion of social citizenship rights, labelling those initiating the process of institutional change as *protagonists*, those actively opposing it as *antagonists* and those how become involved first in subsequent stages of the policy making process often motivated by strategic concerns as *consenters*.[66] This way of thinking about actors' strategies, as dependant on the power structures and institutions surrounding them, is incorporated into the analysis. This insight is emphasised here as it is deemed important for how method of analysis when interests and influence is ascribed to the actors engaging in redistributive conflicts.

4.4 Data collection: Elite interviewing, documents and literature

In order to study preferences and actions of different actors and in order to generate data on the many turns of the development of policing health care policy, interviews were carried out with representatives of organisations involved in this process, government officials and observers of the process working in fields related to public policy or health care.[67] The purpose of the interviews was partly to corroborate information obtained from other, written sources, to establish the perspectives taken by different actors on the issue under investigation and most importantly to reconstruct the set of events leading up to the identified propositions of reforms.[68] The respondents were chosen on the basis of their position in relation to the process under study, choosing respondents who are particularly well informed about the issue or actors

[63] Mahoney & Thelen (2010) p. 18ff.
[64] Hall (2010) p. 206f.
[65] Collier & Collier (1991).
[66] Korpi (2006) p. 182.
[67] Interviews are mentioned by George and Bennett as one of the primary research tools to be used when applying the process tracing method (2005) p. 6.
[68] The use of interviews as a method of data collection contributes to shedding light on elements of the political process which are difficult to unravel looking only at outcomes or written sources. See Tansey (2007) p. 766.

who are central to the decision-making process. However, representatives of all actors involved have not been interviewed resulting in asymmetries in the data as a result. This problem has however been tackled by incorporating written sources which could account for the aspects not covered by the interviews.[69]

The interviews were conducted in a semi-structured fashion, meaning that a set of questions was elaborated, but that these mainly served as a guide setting the framework for the conversations that developed. The questions also provided a checklist of theoretically relevant issues seeking their answers. The main reason for not choosing a more structured method of interviewing was a wish not to let any preconceptions determine the answers, this allowed the interviews to incorporate new variables and perspectives which could have been lost if a more narrow scheme had been applied. However, using open ended questions also have set-backs; answers might be difficult to compare to those of other respondents or written sources and long elaborations on matters deemed important by the respondent might divert attention from the themes which are the focus of the study. As well the biased positions of the respondents might influence the results of the study, an aspect dealt with by viewing the actors under study in their historical context, taking the calculated and strategic behaviour of such actors into account.[70]

The analysis of the Bolivian health care reform also builds on written documents from various sources. Documents have been gathered during the field study and throughout the phase of writing this thesis, and include accounts from Bolivian authors on the development of the Bolivian social insurance system, articles from the press, and official documents. These documents are read selectively, focusing on the most relevant parts, and their descriptions on crucial aspects of the case are compared in order to construct an analysis based on a broad set of sources.

[69] For more information on how the interviewees were selected, see the Appendix.
[70] Bates et al (2000) p. 4.

5 Case study: The right to healthcare in Bolivia

5.1 The origins of social insurance

Through the revolution in 1952, the labour movement entered in a cross-class alliance with urban middle classes and the peasants' movement, which granted the then newly founded Workers Central Union (COB) influence over the government. The revolution thus gave organised labour a momentum and shifted the power balance in society, disfavouring the traditional oligarchy and empowering the emerging labour movement and middle classes, with important institutional changes as a result. However, the labour movement never came to be united politically through a workers' party; instead they supported the governments of the populist Nationalist Revolutionary Movement (MNR). While the peasants' movement supported the revolution and managed to push through an agrarian reform, the influence of the indigenous rural population over the government remained elusive.[71]

The Bolivian social security law was passed in 1956, signalling the inception of the country's social security system. The legislation was conceived in the aftermath of the national revolution of 1952, during the presidency of Hernán Siles Suazo.[72] It was elaborated through a collaboration of representatives from the International Labour Organisation (ILO), national specialists and a committee of deputies. The law included sickness, maternity, old age, work injury and family benefits as well as social housing, and was to be funded by contributions from employers, employees and the government. However, already in 1951, the law on Obligatory Social Insurance had created the National Social Security Fund granting provisions to workers and their families, after a proposal drafted by a technical commission with representatives from the Spanish government and influenced by the Iberian-American Social Security Organisation (OISS) and building on previous labour market regulations.[73]

The development of social insurance following the national revolution of 1952 clearly illustrates a phase during which the organised working class may indeed be labelled protagonists in this process of welfare state expansion. The institutions were changed following a significant empowerment of the popular classes through the formation of a cross class alliance including workers, peasants and the middle classes and the universalisation of suffrage realised by the revolution. However, the corporatist character of social insurance reflects a heritage from previous arrangements and the influence from the ILO, OISS and other foreign representatives,

[71] Farah (2006).
[72] Código de Seguridad Social (1956), see also Picado Chacón & Durán Valverde (2007) p. 26.
[73] Bocangel (2004) p. 56.

as well as the concentration of salaried workers to a few mining centres which diminished the base for truly universal policies.

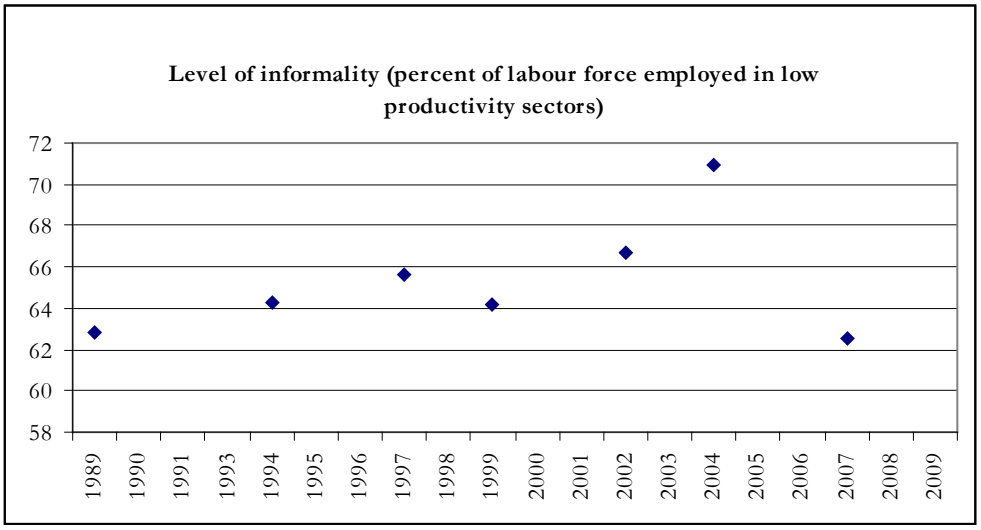
5.2 Labour market and social policy dualism

At the time of inception of the social insurance system, state driven industrialisation was thought to foment the formalisation of the labour market resulting in a gradual extension of social security to the entire population. Labour market dualism is however a persistent feature of the social reality of contemporary Bolivia due to ambiguous processes of economic development and de-industrialisation.

Due to the competition from external markets, small peasants have growing difficulties to sustain their families from the incomes generated by their farming activities. Simultaneously, production on bigger farms has become more capital-intense, diminishing the demand for labour power in rural areas and generating an increasing urbanisation.[74] These pressures have caused peasant production to fall steadily as a share of total agricultural production from 82,2 percent in 1963 to 39,5 percent in 2002.[75]

Characteristics of the changes in the Bolivian labour market following the politics of structural adjustment introduced during the 1980s were sub-contractation of work to smaller non-unionised workplaces and a sharp reduction in public employment, which was not compensated for by the formal private sector.[76] Even within the formal sectors short term and temporal contracts have become increasingly important, making work more precarious and excluding many salaried workers from the social heath insurance system.[77] Although unemployment has remained at relatively low levels, underemployment has become an increasingly important phenomenon,[78] and the Bolivian labour market now has the highest level of informality in Latin America, with a majority of the population employed in this sector.[79]

[74] Webber (2011) p. 29f.
[75] Webber (2011) p. 28.
[76] Kruse (2010) p. 166.
[77] Webber (2011) p. 23.
[78] Kruse (2010) p. 167.
[79] ECLAC/CEPALSTAT.

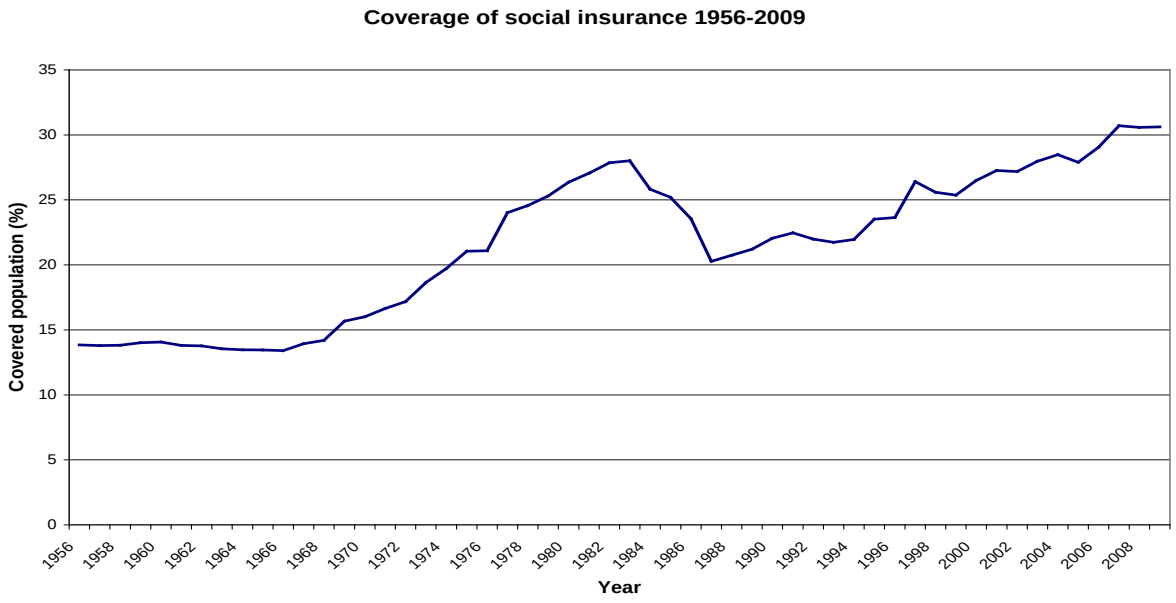


Source: Own elaboration based on data from ECLAC/CEPALSTAT.

The high levels of informality do not only imply that only a small part of the population enjoys the benefits associated with stable full-time employment, such as the right to social health insurance, but it also has several implications for the capacity of unions to mobilise for the extension of benefits. This process significantly weakened the position of the once so vocal Bolivian labour movement, articulated trough the COB.[80]

The inability of the national health system to satisfy the health needs of the population has thereby lead to a change in the course of politics through the *accumulation of failure*.[81] As we shall se in the following section, this has led to a negative diagnosis of the health care system, shared by a majority of the actors involved. The corporatist health insurance funds have however remained largely intact, resisting attempts both towards privatisation and socialisation. This development points to the benefits of conceptualising the inception of social insurance as a contingent event, with far reaching implications for the subsequent institutional development.[82]

[80] Graham (1997) p. 2, 4.
[81] cf. Palier (2005) p.134.
[82] cf. Mahoney (2000) p. 528.



Source: Own elaboration based on INASES (2009): *Anuario Estadístico 2009*.

The changes in the Bolivian labour market point towards an increasing importance of an informal sector in urban areas, at the same time as important parts of the population remains in the countryside, where the incidence of extreme poverty reaches 63,9 percent.[83] However, the low coverage of social insurance is not a new phenomenon in Bolivia and coverage levels of the contributory system have tended to increase, albeit slowly, despite high levels of informality. As the following chapter shows targeted non-contributory programs directed towards previously excluded segments of the population have been gradually expanded during the 1990s and the current universal policies have indeed been launched following an increase in labour market informality during the first part of the 2000s. The relationship indicated by this correlation needs to be associated with a mechanism in order to be labelled causal. This decline of formal work creation and thereby traditional labour's capacity to mobilise has indeed been parallel to an increasing mobilisation of the peasant and informal sectors, often with an ethnic character. Bolivia is a highly divided society in terms of ethnicity, with 39 ethnic groups gathered in a country nowadays labelling itself as plurinational. With a majority of the population auto-defining themselves as indigenous[84] and with social organisations labelling themselves likewise exerting increasing levels of political influence, social mobilisation on ethnic grounds has become an important feature of Bolivian political processes. The marginalisation of the indigenous population has serious implications for the access of these groups to adequate healthcare. For example in the Chiquisaca department, 74 percent of the population is

[83] INE (2011).
[84] Webber (2011) p. 1.

indigenous and the incidence of poverty is 70 percent. Simultaneously the coverage of social insurance is only 18 percent, the lowest in the country.[85] The convergence between the ethnic and socio-economic cleavages in the Bolivian society makes ethnically motivated mobilisation an important feature of class based political action, but the formal/informal cleavage is also reflected in tensions between sectors. The largest peasants' organisation, the CSUTCB, is moreover part of the COB, but the relationship within this alliance is associated with tension due to the division of power within the confederation, which by tradition is governed by mining sector workers.

5.4 Continuity and change in healthcare policy

Despite the tendencies towards de-industrialisation, the social security law from 1956 is still in force, albeit with important modifications, and social health insurance has grown to become the most important subsystem in the Bolivian national health system, accounting for almost 40 percent of total funding in 2009.[86] As with state-corporatist institutions in Europe, the Bolivian health insurance system has proven to be highly resistant to change.

This salience of social insurance can be explained by the way that social polices structure the interests of the polity towards the existing institutions. The existence of fragmented social insurance with a number of independent institution protecting formal workers in case of sickness has impacts on the preferences of these workers. The uncertainty involved with changing the institutional arrangement put in place detracts desirability of the protected workers from embarking on path departing reforms. The lack of financial support from the government and even reluctance from the state to make the proper contributions demanded from it as an employer has over time fostered a feeling of apartness of those defending the independence of the social insurance funds. This has led to a defensive stance of working class organisations and fortified resistance to later attempts from the government to intervene in the funds. Also, the number of entities administering social insurance has increased over the years, from three originally to eight today, and with fragmentation and political interference the funds has become major cites of patronage, nepotism and corruption.[87] Moreover, the corporatist model institute the sector based unions as important veto-players in healthcare reform. These traits have contributed to a mechanism of reproduction of the social insurance funds through the mobilisation of personalised, organisational and sector-based

[85] Mesa-Lago (2009) p. 181.
[86] WHO (2011).
[87] Bocangel (2004) p. 69.

interests. However, on top of the contributory system, a public subsystem gradually expanded through a process resembling what Kathleen Thelen and others have called layering.[88]

Since the reinstallation of democracy in 1982, after a series of military governments, the government of the left wing party Democratic and Popular Unity (UDP), with Hernán Siles Suazo as president for the second time introduced the concept of health as a human right and launched several public programs, including health brigades in rural areas, vaccination campaigns and free medical care at childbirth. Also, popular participation at the local level was fomented through the creation of popular health councils. The focus of this period was to a large extent inspired by the diffusion of the principles of the International Conference on Primary Health Care held in Alma Ata in 1978.[89] As well, the popular characteristics of the government can be seen as a result of the reintroduction of electoral democracy and the sustained struggle by popular organisations against military rule. Although political instability and economic crisis during the 1980s hindered many of these efforts to be further deepened, they marked the introduction of the principles of primary care in Bolivian health care politics and would come to influence the future development of public programs in the country. By introducing and deepening public programs focusing on rural areas, there was a growing affinity between medical professionals devoted to social medicine and social and community organisations. Processes of socialisation both on a local level and through the influence of IOs thus fostered the expansion of public engagement in primary health care.

Starting in 1989, propelled by increased efforts to enhance policy diffusion by IOs, a number of public programs with a targeted focus directed towards the precarious health situation of women and infants were launched. These were managed by the Ministry of Health with important financial contributions from the WB and the Inter-American Development Bank (IADB), and with technical assistance from WHO and UNICEF.[90] In 1994, during the first presidency of Gonzalo Sánchez de Lozada, a basic package of 25 services free of charge to all pregnant women and children under the age of five was introduced.[91] It was partly funded by public funds from the national treasury, which had been transferred to the municipalities as a part of the move towards a more decentralised state structure.[92] Parallel to the introduction of public programs focused on maternal and child health, another set of reforms were introduced in order to provide healthcare to the older segments of the population, at a first stage to all citizens above the age of 65 and later also including those above 60. By gradually introducing

[88] Mahoney & Thelen (2010), Streek & Thelen (2005).
[89] Interview: Crespo (2011), WHO (1978).
[90] OPS (2002) p. 4, Interview: Aguilár (2011), Interview: Cuentas (2011).
[91] Galindo Soza (2010) p. 16.
[92] Ibid.

modifications to these programs a system of public insurance schemes was gradually expanded between 1994 and 2006.

In 1997 The Ministry of Health launched a special health reform project, managed by a WB financed project team and thus heavily influenced by the bank's agenda. The focus the reforms introduced during the presidency of Hugo Banzer and Jorge Quiroga was explicitly to enhance equity in the health care system but it retained an emphasis on targeting towards the most vulnerable groups in society. Particularly, the reforms followed the recommendations of the WB to focus on malnutrition, communicable diseases, childhood illnesses, high fertility, and maternal and perinatal conditions; targeting resources to where their use was thought to be most effective.[93]

These gradual reforms were introduced by Supreme Decrees and incorporated the municipalities only on voluntary basis through the signing of particular agreements. Thereby, potential veto-points were bypassed, avoiding regional opposition. However, this also meant that the healthcare programs remained vertical and that the structures envisaged by the reforms were not comprehensively implemented or regulated.[94]

An important change came in 2003 with the introduction of the Universal Mother and Child Insurance (SUMI)[95] which has a more universal character in terms of provisions, thereby breaking the emphasis on a minimal package as advocated by WB.[96] SUMI has three sources of funding: the national treasury, the municipalities and the National Solidarity Fund.[97] The law stipulates the right of all pregnant women and all children up to the age of five the right to basically any health service,[98] and this time the reform was established by law thus consolidating the system of public insurance schemes.[99] Efforts to extend the scope and functionality of the existing programs were made during the 2003-2005 period, partly through the WB supported program EXTENSA, deploying health teams in rural areas, but these were largely unsuccessful due to political instability and fiscal constraints.[100]

As illustrated by the reforms referred to above, the national health system evolved through a series of amendments to the old system, surpassing the limits of contributory insurance and gradually strengthened the government's capacity to regulate and execute a

[93] World Bank (1997) p. 6.
[94] Galindo Soza (2010) p. 23, Tejerina et al (2011).
[95] Seguro Universal Materno Infantil.
[96] Estado Plurinacional de Bolivia (2002).
[97] The fund was introduced in the year 2000 following the HIPC II process relieving the debt for heavily indebted countries.
[98] The number of services mentioned explicitly in the protocol is 547, however as long as a treatment is not explicitly excluded by the law, such as the case with chemotherapy, aesthetic surgery, proteases etc. it is to be provided to the patient, free of charge. See UDAPE/UNICEF (2006) p. 32.
[99] Galindo Soza (2010) p. 23.
[100] World Bank (2009) p. 3, World Bank (2005) p. 9.

national health care policy. Through layering of institutional rules, a network of public health facilities developed throughout the country, due to expanding primary health programs and the decentralisation of responsibilities to the municipalities. This expansion of public healthcare programs also coincides with changes in the state structure as well as in the state-society relationship. In order to analyse the emergence of a new momentum in healthcare policy we therefore turn to this processes in the following section.

5.5 A new political context: decentralisation and social mobilisation

Following the reforms of the state structure and the introduction of laws on popular participation and decentralisation, there has been a gradual incorporation of community based interest organisations into Bolivian state-society relations. By launching their own platforms, social organisations started to challenge the traditional political parties, initially at the local level and later nationally, provoking the breakdown of the previous party system.[101] The power resources of the informal and agrarian sectors seem to be enhanced by several institutional factors. First, the re-installation of democracy enhanced the efficacy of the power resources of these sectors through the extension of suffrage. As well, a decentralised state-structure gives community based organisations increased influence over public policy making. This extension of the state to areas previously alienated from state politics also generated a political logic which turned community based organisations towards political action and involvement in public decision-making. These movements represented communities excluded from access to the health care system, making claims about the improvement of living conditions in their communities, including health care. Thus, increasing political competition came to account for an interest from politicians to expand the existing programs, sometimes opposing the strict targeting promoted by IFIs.

However, state capacity has been weak both in terms of legitimacy and financial capacity, which has refrained the government from launching more radical reform proposals. Since the 1980s Bolivia had a large external debt and the economy experienced only slow growth while the government was running a deficit during the first years of the 21st century.[102] Between 2000 and 2005 there was also continuous social unrest and political instability. The weak capacity of the Bolivian state facilitated the entry of the WB and other IOs, whose concern have mostly been with improving the efficiency and efficacy of the system and not with comprehensive reform. Moreover, the presence of a number of political parties in the legislative

[101] Albó (2008).
[102] Weisbrot, Ray & Johnston (2009).

assembly during this period made the congress and senate potential veto-points were more comprehensive reform could be blocked.

This was the background to the emergence of MAS-IPSP as the dominant force in Bolivian party politics. In the 2005 elections Evo Morales, the leader of MAS-IPSP and a former peasants' union leader and deputy in congress, gained the presidency with 54 percent of the votes. The party also managed to gain a majority in the national congress, but won only 12 of 27 senators, thus giving the opposition the possibility to veto the government's proposals. Also, MAS-IPSP only gained three of nine departmental prefectures. This situation made the governing party forced to negotiate new legislation with the opposition both on a national and regional level, with implications for the development of new health care policies. An important leverage of the nine regional departments stems from their control of the revenue from the Direct Tax on Hydrocarbons (IDH) introduced by the Morales government.

MAS-IPSP is strictly speaking not a political party, but a vehicle for a coalition of social organisations representing peasants and indigenous peoples, and has gained electoral support of the traditional labour unions. A new cross-class alliance thus seem to have emerged, including peasants' and indigenous peoples' organisations in coalition with organised labour and an urban left wing middle class, with significant tensions arising between the different factions within the MAS-IPSP.

Following the widespread mobilisations during the first years of this century, constitutional reform was brought forward by the social organisations as a principal objective. Also, sector specific pre-constitutional assemblies were set up in order to elaborate new policies which would form the base of a new constitution. Departmental assemblies were carried out in all departments, conformed to 70 percent by representatives of social organisations and to 30 percent by representatives of the health care system, to discuss the status of health in the new constitution. These were followed by a national assembly in 2006 in Sucre, were a document was elaborated, drawing up the guidelines for the new constitutional paragraphs on health.[103]

The process of constitutional reform was interwoven with the elaboration of new polices for the health sector. Healthcare for all was a part of the electoral campaign which brought Morales to the presidency in 2005, although the issue was largely overshadowed by the nationalisation of natural resources and the promotion of indigenous people's political rights. The new strategy identified by the MSD during the first year of the new government pointed to

[103] Interview: Jemio (2011), Interview: Maturano (2011), Ministerio de Salud y Deportes (2007) p 21ff.

the state as a protector of the universal right to health and emphasised the importance of recognising cultural diversity and popular participation as parts of a new sanitary model. [104]

The new constitution, adopted in 2009, after being approved in a referendum in December 2008 recognises health as a fundamental right of all Bolivian citizens. The access to health care is to be guaranteed by the state. Furthermore, the constitution prescribes a universal unified healthcare system and the abolishment of out-of-pocket expenditure for public care.[105] Also, government is given the responsibility to develop policies which improve access to free healthcare services and guarantee access of the entire population to a universal health insurance. Another article explicitly prohibits the privatisation of public health services. [106] The direct references between the constitutional document and the programs elaborated by the MSD are results of the interwoven processes of state transformation and renovation of healthcare policies which have taken place during the last decade, with the redefinition of the state-society relationship underlying both. The political and administrative leadership, heavily influenced by the social medicine tradition and especially the Latin American Association of Social Medicine (ALAMES), have also been active in the constitution-making process, thus generating this coherence of political goals and strategies.

The new constitution was passed by bypassing potential institutional veto-points by the use of a referendum called at the discretion of the executive, thereby enhancing power concentration. The event shows how institutional constraints can be overcome by agency in the form of massive popular mobilisation combined with a presidentialism with populist characteristics. [107]

One trajectory of the policy process can thus be traced from the demands raised by social organisations which eventually made their way into the electoral program of the MAS-IPSP, reaching the status of government policy after the 2005 elections, and eventually making their way into the country's new constitution adopted in 2009. [108] Another path of policy influence emanates from the global level and the international flow of ideas and pressures discussed in the following section

[104] Ministerio de Salud y Deportes (2006).
[105] Estado Plurinacional de Bolivia (2009) p. 7.
[106] Estado Plurinacional de Bolivia (2009) p. 13f.
[107] Cf. Bonoli (2001) p. 243.
[108] Interview: Jemio (2011).

5.6 Regional networks and policy diffusion

As the events referred to earlier shows, IOs and foreign governments have been influential in healthcare politics due to the insufficient capacity of the Bolivian government to raise sufficient funds and plan the implementation of healthcare programs, especially during the 1990s. With the introduction of the structural adjustment programs, the more comprehensive primary care strategy introduced during the 1983-85 period was moulded into a more selective approach as promoted by the WB, IADB, WHO and UNICEF.[109]

Since 2005 Bolivia has had large shares of the country's external debt cancelled as a result of the dept relief to Heavily Indebted Poor Countries program (HIPC), at the same time as the national economy has started to improve, thus diminishing the government's dependence on foreign aid.[110] IOs are however still present in healthcare politics and the WBs reform project has been partly continued through the *Expanding Access to Reduce Inequities in Health* project. The financing agreement states that the WB, through the International Development Association, is to assist the MSD with technical assistance and financing in matters such as advocacy of the ministry's sectoral plan as well as for the rollout, planning, management, monitoring and evaluation of the proposed universal insurance.[111] Thus, the WB does not seem to have opposed any of the ministry's proposals, but rather been supportive of the reform agenda.

Perhaps most important among international influences for the development of healthcare policy in Bolivia today is instead the ALAMES, to which several of public officials in the MSD are linked. [112] The organisation promotes the creation of universal social security systems financed through progressive taxation, and interprets universalism as a part of an amplified citizenship, a matter of government responsibility and of public predominance. Also, social mobilisation and popular participation are important components of reform according to ALAMES and the network promotes close collaboration with popular movements, also a core message of the current new Bolivian sanitary model.[113]

After the election of Evo Morales Bolivia became a part of the regional network called the Bolivarian Alternative for Our America – the Peoples' Trade Agreement (ALBA-TCP), founded by Cuba and Venezuela in 2004, which according to the MSD constitutes "a new regional framework for the cooperation and solidarity between the peoples".[114] Within this

[109] Tejerina et al (2011) p. 23.
[110] Weisbrot, Ray & Johnston (2009).
[111] IDA (2008) p. 5.
[112] Interview: Maturano (2011), Interview: Crespo (2011).
[113] Torres (2007) p. 1. Ministerio de Salud y Deportes (2010) p 64.
[114] Ministerio de Salud y Deportes (2010) p 45, my translation.

framework 1921 Cuban doctors have been deployed in rural areas in Bolivia, providing healthcare without charges for services.[115] Within the ALBA, Venezuela is embarking on a similar path as Bolivia, with the construction of a universal National Public Health System built on an extension of the project Barrio Adentro.[116] The Cuban health care system is an example of a consolidated pure public system with a high profile in the region. Simultaneously, Cuba has recently reformed its' system by increasing the emphasis on family health, a process which have been observed by Bolivian decision makers.[117] The collaboration within the ALBA framework might thus appear important by making already implemented health policy models available to Bolivian decision makers and by the influence of closer relationship of decision makers from the countries participating within this framework. However, the sequence of events rather implies a reverse causality between the composition and ideology of the Bolivian government and international collaboration. The healthcare policy of the MSD, MAS-IPSP and the public officials promoting universalism predates the closer relationships with Venezuela and Cuba.

However, this does not exclude that availability of healthcare policies pursued in other countries influence the decision-making in the Bolivian case. The development of a Unified health system in Brazil has also received attention and has served as an example of how universalisation can be pursued by emphasising the role of public provisioning.[118] There have also been tendencies to observe the processes of unification of health care systems in industrialised countries, such as those that have taken place in southern Europe.[119]

These findings thus indicate that the Bolivian government has come to adopt a more independent relation towards global IOs and IFIs, but that the global dimension remains important for the process of policy diffusion. The regional networks show that not only cultural and geographic closeness promotes diffusion, but that this process also has a political dimension. This dimension has two implications on the diffusion of policy; first, that domestic power struggles shapes the emergence of networks and channels of policy diffusion on a global level, and therefore that, secondly, which models get attention by decision-makers is partly decided as a result of the outcome of these struggles. Although general ideas about efficiency and equity, spread by IOs and IFIs as well as the ALAMES, have been adopted by the MSD, there is also a tendency towards model diffusion as shown by the attention paid to the design of

[115] Gran Álvarez (2008).
[116] Ministerio de Poder Popular para el Salud & Ministerio de Poder Popular para la Planificación y Desarrollo. (2009).
[117] Ministerio de Salud y Deportes (2009) p. 50.
[118] Ministerio de Salud y Deportes (2009) p. 51.
[119] Interview: Crespo (2011).

the Cuban, Venezuelan and Brazilian reforms, in spite of the complexity of healthcare systems.[120]

5.7 A healthcare system at a point of path departure?

The demands for the right to health for all and the necessity of unifying the health care system has not been disputed in the debate over health care policies, instead the diagnosis of failure of the Bolivian health care system is shared among the main actors.[121] Rather, it is the organisation of the system in general, and its' funding and redistribution of power in particular, which have been up to debate.

The government program of the MAS-IPSP launched previous to the 2005 elections, introduces expansion of the public sector to cover for the population not insured by social security as a first step towards a unified health care system.[122] After the 2005 elections, a universal public insurance was proposed in order to achieve universal access to the national health system. Fiscal constraints made the government suggest a first stage in 2007, extending access to free health care to all non-insured citizens up to 21 years of age. The extension was to be financed by a combination of the departmental and municipal funds complemented with resources from the National Solidarity Fund.[123] This proposition was however not passed by the senate due to the conflicts arising from the centralisation and redistribution of decentralised departmental resources included in the proposal.[124]

This instance illustrates how the process of decentralisation serves both as channel of pressures for reform and an obstacle to national initiatives. On one hand, the process of decentralisation launched during the 1990s, an the subsequent transfer of funds to the municipalities paved the way for increased investments in primary health care facilities at the local level as a response to popular demands.[125] Also, some departments, many governed by oppositional forces, had already launched autonomous public health insurance programs with the funds from the IDH when the MSD brought its' proposals for a universal insurance to the congress. On the other hand, the opposition to the governments' proposed financing mechanism was able to halt its' implementation by articulation of this resistance in the senate by

[120] Cf.Weyland (2006).
[121] Interview: Cuentas (2011).
[122] MAS-IPSP (2005).
[123] Cámara de Diputados (2007).
[124] The current distribution of revenues from the hydrocarbon industry gives the four eastern departments 30 percent while the five highland departments receive 19,7 percent, although the population in the latter departments exceed that of the former ones by 79 percent (Webber 2011:129). All four departments in the eastern lowlands, Pando, Beni, Santa Cruz and Tarija, opposed SuSalud. See Santa Cruz (2010).
[125] Interview: Aguilar (2011).

forces demanding increased regional autonomy. This backlash for the process of health insurance expansion also illustrates the conflicts involved in determining the mechanisms of financing, thus highlighting the redistributive aspects of institutional change. It also introduces the sub-national governments as important veto-players in the process of health sector reform and highlights the inter-regional tensions underlying the political debate in Bolivia. As well, it shows how the political institutions work to structure the process of reform and provide opponents of reform with a strong veto point in the national senate.

This moment was then followed by a period of partial reformulation of the priorities of the MSD parallel to new changes in the political context. In 2008 a new constitution recognising the right to health as a fundamental right to be provided guaranteed by the state was approved by referendum. Also, with the passing of the new constitution autonomy was granted the departments, municipalities and indigenous communities[126] Increased electoral support for MAS-IPSP in the 2010 elections gained Evo Morales a second term as president and the party a majority of the seats in the chamber of deputies and the senate, as well as six instead of three departmental prefects. This result has given rise to increased power concentration to the executive, making opposition to government policy in the parliament inefficient. However, MAS-IPSP lost mayoral elections in important cities, including La Paz. Bargaining over the limits of regional and local autonomy is thus a continuing feature of Bolivian politics.

After a decades of incremental reforms pushed forwards both by IOs and domestic politicians, the public subsystem has positioned itself as an important provider of healthcare services and an insurer, especially in rural areas where the social insurance system is weak. The position acquired by the public system has thus put the MSD in a position were it is seen as feasible by public officials to build a unified system on the existing public network, a situation much different from that during the return to democracy in 1982 when comprehensive reforms were considered in the light of the Ala Ata conference.

In 2010 the MSD launched a series of departmental health congresses were the new proposals for a unified healthcare system were debated and delegates were elected to a national health congress held in January 2011. During this national congress the proposition delineating the design of the new Unified Health System (SUS) was debated and agreed upon in, the presence of representatives from the health sector and social organisations.[127] However,

[126] Bolivia (2009) p. 79.
[127] Ministerio de Salud y Deportes (2011b).

during this congress the refusal of the COB to participate, due to disagreements with the policies of the MSD, reflects the conflicts over the new reform.[128]

Primarily, MSD would like to have seen the healthcare funds integrated into a comprehensive public system. The proposal for the SUS from January 2011, however, states that the funds are to sign agreements with the MSD in order to coordinate their activities with the SUS and integrate them into the single system.[129] This somewhat vague formulation, allowing the health insurance funds some degree of independence within the reform, is the result of the conflicts which have arisen around the issue of the health insurance funds' future, reflecting different sector based interest. However, this procedure with a public system covering those not insured by social insurance, corresponds to the first step towards a unified healthcare system as outlined by the MAS-IPSP.[130]

5.8 Protagonists and antagonists in the struggle over universalism

The public officials within the MSD stand out as clear protagonists in the process of universalisation. These often have strong ties to social organisations or left wing parties, and often claim to be working for the benefit of the entire population. The current government benefits from a wave of mobilisations of community based organisations in both urban and rural areas, and enjoys its' strongest support form organisations representing the indigenous population. Urban organisations representing immigrants from the countryside and informal sector workers include for examples gremial organisations and neighbourhood assemblies, reflecting the new forms of social mobilisation emerging in the country. Since the re-installation of democracy in 1982 Bolivia has seen a gradually increasing importance of peasant workers' unions, women's organisations and social organisations, with the extension of social rights on their agenda.[131]

Simultaneously, the primary and most articulate antagonists of healthcare reform are sector based interests whose positions are threatened by a decomposition of the social health insurance system. Doctors and medical workers fear reduced professional autonomy, rationalisations and system collapse, and coincide with the traditional labour movement over the risk of a deterioration of the quality of services if social insurance is to be integrated with the public subsector. The resistance of these movements to the MSDs policies most often takes the form of strikes, marches and blockades. In order to highlight these tensions, some

[128] El Cambio (2011-01-21).
[129] Ministero de Salud y Deportes (2011a).
[130] MAS-IPSP (2005).
[131] See Albó (2008), MAS-IPSP (2005).

illustrations of the reactions of organised interests to the government initiatives are restated below.

As a move towards strengthening government control over the health insurance funds' resources, the budgetary law for 2011 demands that the funds' financial resources are deposited in accounts supervised by the ministry of finance. [132] The union of doctors in the social insurance system (SIMRA) [133] of La Paz has signed a joint statement with the COB, denouncing this move by the government. The SIMRA, as well as the COB, supports the idea of a unified health system with universal access on a general level but does not approve of an integration of the social insurance system with the public system, claiming that coverage of non-contributing workers should be made by public funding and not with resources from the social insurance contributions.[134]

The resistance to healthcare reform coincided with a general strike for raised salaries, carried out during ten days in April 2011, when the roads and city centres were blocked by demonstrators. During this strike the minister of health, Nila Heredia, was denounced for having an anti-worker posture. In response, the government launched the proposal of moving all public employees currently insured with the social health care funds to a new public insurance scheme, and introduced the proposal of resolving the issue trough a national referendum.[135] Likewise, in March 2011 the professional organisation of doctors in Bolivia, the Colegio Médico, launched a twenty four hour strike opposing a new law regulating the medical profession, but also the proposal for a unified healthcare system, disapproving of the incorporation of the social insurance funds with the public system.[136]

The trade unions are important stakeholders in the political process for a number of reasons. First, since the funds responsible for managing the social health insurance system are co-managed by representatives of the state, labour and employers, these instructions offer union representatives a channel of influence. Second, the COB perceives the social security system as patrimony of the workers, originating from their struggles as well as their contributions.[137] Third, although with wide differences between geographical areas and between different funds, affiliation to the funds puts the formal sector workers in a privileged position vis-à-vis other sectors. Finally, health care workers in the social insurance sector have joined the

[132] Cf. Bolivia (2010).
[133] Sindicato Médico y Ramas Afines.
[134] Interview: Pereira (2011).
[135] La Razón (2011-04-12), Interview: Aguilár (2011)
[136] El Cambio (2011-03-24).
[137] Interview: Izquierdo (2011), Interview: Pereira (2011).

COB in mobilisations against reforms for fear of a collapse of the infrastructure built up by social insurance if contributions from this system are to fund the proposed reform.

Simultaneously, the role of private employers has been marginal throughout the policy making process. While the medicine industry has been noted to benefit from the present fragmentation of the system and thus show certain resistance to any attempts towards increased centralisation their impact on the policy making process is negligible.[138] As long as it does not imply an increased financial burden of employers in the form of new raised taxation or increased employer contributions, [139] private enterprises can be labelled consenters in the current process of reform.

Instead of traditional working class organisations, the health care reform has found its' supporters within groups formerly excluded from social insurance. Recently, the government has decided to abort all discussions on including particular sectors, favouring a universal approach to the process of increased access. In the discussions on the current reform proposals, domestic service workers for example, who previously pushed for a sectorial agreement now have hopes of a unified system granting the right to health care for all who previously have been excluded.[140] As well, as the COB launched its' general strike against the government, several indigenous organisations came out in defence of the governments general reform ambitions.

[138] Interview: Maturano (2011)
[139] Interview: Peñaranda (2011)
[140] Interview: Cuenta (2011)

6 Conclusion

What do theories of welfare states and institutional change tell us about the development of universal social policies in countries characterised by dual labour markets and entrenched contributory social security institutions? The tracing of the process of institutional change within Bolivian healthcare policy has highlighted a need to modify, or at least contextualise, some of the hypotheses drawn from theory.

Starting with the process of policy diffusion we have seen that the Bolivian reform agenda have been heavily influenced by external actors. The adoption of foreign ideas has however largely followed the development in domestic politics. As well, external influence seems to be most important when state capacity is reduced, as was the case in Bolivia during the 1980s. Moreover, in the absence of heavy dependence of particular sources of external funding, ideological affinity and the composition of social organisations pushing for reform are of primary importance for the type of policy that gets attention. As for the comprehensive reform proposed by the current government, the international influence has been more profound within civil society networks, than within inter-government networks such as ALBA. The extension and influences of these non-state networks as well as the linkages between power and policy diffusion thus stand out as important areas for further research.

An orthodox reading of the PRA might lead us to the conclusion that the emerging proletariat would be the protagonists in driving universalisation forward. The Bolivian case however, shows how the institutional context might put the labour movement in a position in defence of contributory social insurance, giving them the role as main antagonists of universalisation. Instead we have seen how an agrarian and urban informal class has formed a political instrument, promoting the extension of social rights. Indeed as T.H Marshall noted, social rights are "woven into the fabric of citizenship" as this citizenship is extended in a society characterised by material inequality.[141] This process is highly related to the transformation of political institution as we have seen how the processes of democratisation and decentralisation raise the question of citizenship among previously marginalised groups.

As for the hypotheses derived from the state-centred approach, the executive has indeed been protagonists in promoting public sector expansion. However, the strong ties between left wing parties, social organisations and the bureaucracy under Evo Morales have put the assumption of bureaucratic autonomy into question. While the public officials may indeed have an interest in increased spending, it appears that the formulation of a comprehensive

[141] T.H Marshall (2009[1950]) p .153.

reform that effectively alters the design of social policy is more dependent on other factors. Rather, public officials on lower levels might have an interest in preserving their current position which might provide them a higher level of autonomy. With this said, state structure indeed seem to be an important determinant of the politics of welfare state reform. In this study the mechanisms of power concentration and dispersion have proved to be important for the possibility for progressive actors to pursue comprehensive reform, as for incorporation of previously excluded groups into the political matrix.

Finally, what about the impact of policy legacies? Indeed as previous research has shown, state-corporatist institutions prove to be effective in generating defensive coalitions making politics highly path dependent. However, the Bolivian case also illustrates how path departing change can be conceptualised as endogenous by focusing on, not only on the patterns of reproduction of a legacy, but also on how this legacy institutionalises patterns of exclusion and thus generates new bases for reformist coalitions when contextual factors change. As well, the gradual layering of institutional features might move the entire system towards a threshold were truly part departing change may indeed be not only possible but also probable given the interaction with other factors such as the level of social mobilisation and the existence of channels of influence for excluded segments of the population.

6.1 Discussion

Social security systems based on formal labour relations are under serious pressure in a context where the informal and agrarian sectors are being increasingly empowered by decentralisation and democratisation processes. While structural adjustment in Latin America did not manage to reduce poverty but rather enhanced inequality and labour market dualism, the simultaneous changes in state structures and the extension of civil and political rights have led to the emergence of movements demanding social rights such as healthcare and education. This pressure can indeed be conceptualised as the result of an enhancement of the efficacy of the power resources of previously marginalised groups. However, the introduction of comprehensive reform will depend on the ability of these groups to form progressive coalitions with labour unions in traditional industrial sectors and with the growing urban middle-classes. The support of these sectors is however contingent on the ability of reforms to guarantee continuity of the benefits granted by previous social security institutions and improve the quality of services. A possible way forward may thus be the strategy of combing mandatory social insurance with universal social services. The funding of such an approach will however be dependent on the ability to develop modern and progressive taxation in order to break the

current regressive distributional character of Latin American welfare states. The willingness to pay taxes is however in turn dependent on the characteristics of social policy pursued, making feedback effects a continuously important factor. Research from an institutionalist perspective will thus be of continued importance for our understanding of the processes of welfare state reform.

References

Albó, Xavier. 2008. "25 años de democracia, participación campesina - indígena y cambios reales en la sociedad", *Bolivia: 25 años construyendo la Democracia*. Viceprecidencia de la República – Precidencia del Congreso Nacional, La Paz.

Armanda, Francisco; Muntaner, Carles & Navarro, Vicente. 2001. "Health and Social Security Reform in Latin America: The Convergence of the World Health Organization, The World Bank, and Transnational Corporations," *International Journal of Health Services*, vol. 31, nr. 4, pp. 729-768.

Barrientos, Armando. 2004. "Latin America: a liberal-informal welfare regime?" in Gough, Ian; Wood, Geof, Barrientos, Armando; Bevan Philippa; Davis, Peter and Room, Graham eds., *Insecurity and Welfare Regimes in Asia, Africa and Latin America - Social Policy in Development context*, Cambrige University Press, Cambrige.

Barrientos, Armando. 2010. *Social Protection and Poverty*, Social Policy and Development policy Paper No. 42, UNSRID, Geneva.

Bocangel Peñaranda, Alfredo. 2004. *Derecho de la Seguridad Social*, Second Edition, Colegio de Abogados de La Paz, La Paz.

de Barros, Ricardo Paes, de Carvalho, Mirela. 2004. *Targeting and universalization as instruments for the reduction of inequalities*, Inter-American Development Bank.

Bergh, Andreas. 2004. "The Universal Welfare State: Theory and the Case of Sweden", *Political Studies*, vol. 52, pp. 754-766.

Bates, Robert H.; Greif, Avner; Levi, Margaret; Rosenthal, Jean-Laurent & Weingast, Barry, 2000. "Review: "The Analytical Narrative Project", *The American Political Science Review*, Vol. 94, No. 3, pp. 696-702.

Bennett, Andrew & Elman, Colin. 2006. "Complex Causal Relations and Case Study Methods: The Example of Path Dependence", *Political Analysis*, vol. 14, pp. 250-267.

Bennett, Andrew& Elman, Colin. 2007.

Bolivia. 2002.*Ley del Seguro Universal Materno Infantil*, Gaceta Oficial del Estado, La Paz.

Bolivia, Estado Plurinacional de. 2008.*Constitución Política de Estado*, Estado Plurinacional de Bolivia, La Paz.

Bolivia, Estado Plurinacional de. 2010.*Decreto Supremo no 0772*, Gaceta Oficial del Estado Plurinacional de Bolivia, La Paz.

Bonoli, Giuliano. 2001, "Political Institutions, Veto Points, and the Process of Welfare State Adaption" in Pierson, Paul ed., *The New Politics of the Welfare State*, Oxford University Press, Oxford.

Büthe, Tim. 2002. "Taking Temporality Seriously: Modelling History and the Use of Narratives as Evidence", *American Political Science Review*, Vol. 96, No. 3.

Cámara de Diputados. 2007. *Proyecto de Ley No 005/2007*, Bolivia, La Paz.

Carnes, Mattew & Mares, Isabela. 2010. *Deindustrialization and the Rise of Non-contributory Social Programs in Latin* America, Paper presented at Duke University, Workshop on Social Policy in Developing Countries.

Carnes, Mattew & Mares, Isabela. 2010. "Social Policy in Developing Coutries" *Annual Review of Political Science*, vol. 12.

Clemens, Elisabeth S. & Cook, Kames M. 1999. "Politics and Institutionalism - Explaining Durability and Change", *Annual Review of Sociology*, vol. 25, pp. 441-465.

Colegio Médico Departamental de La Paz. 1999. *Propuesta para la Reforma de Salud*, Colegio Médico Departamental de La Paz, La Paz.

Collier, Ruth Berins & Collier, David. 1991. *Shaping the Political Arena – Critical Junctures, the Labor Movevent and Regime Dynamics in Latin America*, Princeton University Press, Princeton.

Collins, Charles, Green, Andrew & Hunter David. 1999. "Health Care Reform and the Interpretation of Policy Context", *Health Policy*, vol. 47, pp. 69-83.
Commision on Social Justice. 2006/1993. "What is Social Justice?" in Pierson, Christopher & Catels, Francis G. eds., *The Welfare State Reader*, 2nd edition, Polity Press, Cambrige.
Deacon, Bob. 2005. "From 'Safety Nets' back to 'Universal Social Protection': Is the Global Tide Turning?", *Global Social Policy*, vol. 5(1), pp. 19-28.
ECLAC/CEPALSTAT. 2011. *Urban population employed in low productivity sectors of the labour market (informal sector), by sex*, available at: http://websie.eclac.cl/sisgen/ConsultaIntegrada.asp?idAplicacion=1&idTema=5&idioma=i, quoted 2011-09-14.
El Cambio. *Médicos realizan paro de 24 horas*. 2011-03-24, available at: http://www.cambio.bo/noticia.php?fecha=2011-03-24&idn=41505, quoted 2011-09-10.
El Cambio. *La COB asegura que no participará en el Congreso Nacional de Salud*, 2011-01-21, available at: http://www.cambio.bo/noticia.php?fecha=2011-01-21&idn=37067, quoted 2011-01-15.
Esping-Andresen, Gösta. 1990. *The Three Worlds of Welfare Capitalism*, Cambrige University Press, Cambrige.
Esquivel Velásquez, Adhemar D. 2005. *Financiamiento de programas públicos de salud en Bolivia – Casos: Chagas Malaria, Tuberculosis e inmunización 1999-2005*, UDAPE, La Paz.
Falleti, Tulia G.& Lynch, Julia F. 2009 "Context and Causal Mechanisms in Political Analysis". *Comparative Political Studies*, vol. 42; pp. 1143-1166.
Farah H., Ivonne. 2006. "Pensarnos más iguales en un nuevo pacto redistributivo", *Umbrales,* no. 14, pp. 155-208.
Filgueira, Fernando; Molina Carlos Gerardo; Papadópulos, Jorge & Torbe, Federico. 2006. "Universalismo básico :Una alternativa posible y necesaria para mejorar las condiciones de vida", in Molina, Carlos Gerardo (ed.): *Universalismo Básico - Una nueva política social para América Latina*, Inter-American Development Bank, Washington D.C.
Galindo Soza, Mario. 2010. *El progreso invisible - El Seguro Universal Materno Infantil*, Fundación Milenio, La Paz.
George, Alexander L. & Bennett, Andrew. 2005. *Case Studies and Theory Development in the Social Sciences*, MIT Press, Cambridge, Massachusetts.
Gough, Ian. 2004. "Welfare regimes in development context:: a global and regional analysis" in Gough, Ian; Wood, Geof, Barrientos, Armando; Bevan Philippa; Davis, Peter and Room, Graham eds., *Insecurity and Welfare Regimes in Asia, Africa and Latin America - Social Policy in Development context*, Cambrige University Press, Cambrige.
Graham, Carol. 1997. "Building Support for Market Reform in Bolivia: The Capitalization and Popular Participation Programs", in Barda, Josef C. ed., *The Deepening of Market Based Reform: Bolivia's Capitalization Program*, The Woodrow Wilson International Centre for Scholars, Washington D.C.
Gran Álvarez, Miriam. 2008. *Estructura de la BMC*, Colaboración Médica Cubana, avlible at: http://colaboracion.sld.cu/paises/america-y-caribe/copy20_of_Paises/composicion-de-la-brigada-medica-cubana/estructura-de-la-bmc/.
Hacker, Jacob. 1989. "The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian and U.S. Medical Policy", *Studies in American Politica Development*, vol. 12, pp. 57-130.
Hall, Peter A. 2003. "Aligning ontology and methodology in comparative research", in Mahoney, James and Rueschemeyer, Dietrich eds., *Comparative Historical Analysis in the Social Sciences*, Cambridge University Press, Cambridge.
Hall, Peter A. 2010. "Historical Institutionalism in Rationalist and Sociological Perspective" in Mahoney, James & Thelen, Kathleen eds., *Explaining Institutional Change – Ambiguity, Agency and Power*, Cambrige University Press, New York.

Homedes, Núria & Ugalde, Antonio. 2005. "Human resources: the Cinderella of health sector reform in Latin America", *Human Resources for Health*, Vol. 3(1).
Hurtado Gomez, Luis. 2000. "Sindicalismo Médico en Bolivia – Apuntes Sobre la Confederación Médica Sindical de Bolivia (COMSIB)", *Archivos Bolivianos de Historia de la Medicina*, vol. 6, no. 2, pp. 17-41.
IDA. 2008. *Financing Agreement - Expanding Access Reduce Inequities in Health Program (APL III)*, International Development Association, Washington D.C.
Instituto Nacional de Estadística. 2011. *Indicadores de pobreza extrema, según área*, available at: http://www.ine.gob.bo/indice/EstadisticaSocial.aspx?codigo=30601, quoted 2011-09-15.
Immergut, Ellen M. 1992. *Health Politics: interests and institutions in Western Europe*, University of Cambridge, Cambrige.
INASES. 2009. *Anuario Bioestadístico 2009*, Instituto Nacional de Seguros de Salud, La Paz.
Korpi, Walter. 1983. *The Democratic Class Struggle*, Routlege & Kegan, London.
Korpi, Walter. 2006. "Power resources and employer-centered approaches in explanations of welfare states and varieties of capitalism – Protagonists, consenters and antagonists", *World Politics*, Vol 58, pp. 167-206.
Korpi, Walter & Palme, Joakim. 1998. "The Paradox of Redistribution and Strategies of Equality: Welfare State Institutions,Inequality, and Poverty in the Western Countries", *American Sociological Review*, Vol. 63(5), pp. 661-687.
Korpi, Walter & Palme, Joakim. 2003. "New Politics and Class Politics in the Context of Austerity and Globalization: Welfare State Regress in 18 Countries, 1975–95", *American Political Science Review*, vol. 97(3), pp. 425-446.
Kruse, Tom. 2010. "Los sindicatos frente a los procesos de transición política – Reflexiones desde Bolivia", in de La Garza Toledo, Enrique, ed*., Los sindicatos frente a los procesos de transición política*, CLASCO, La Paz.
La Razon. 2011-04-11.
La Razon. 2011-04-12.
Levkovitz, Eduardo. 2006. *Desafíos de la protección social para la organización de los sistemas de salud en América Latina y el Caribe*, paper presented at the Regional American Conferance of the ISSA in Belize City, ISSA..
Mahoney, James. 2000. "Path Dependence in Historical Sociology", *Theory and Society*, Vol. 29(4), pp. 507-548.
Mahoney, James. 2001. "Beyond Correlational Analysis: Recent Innovations in Theory and Method." *Sociological Forum* 16(3): 575-593.
Mahoney, James & Thelen, Kathleen. 2010. "A Theory of Gradual Institutional Change" in Mahoney, James & Thelen, Kathleen eds., *Explaining Institutional Change – Ambiguity, Agency and Power*, Cambrige University Press, New York.
Mares, Isabela & Carnes, Matthew E. 2010. "Deindustrialization and the Rise of Non-contributory Social Programs in Latin America," paper presented at the Duke University, Workshop on Social Policy in Developing Countries.
Marshall T.H. 2009[1950]. "Citizenship and Social Class", in Manza, Jeff & Sauders, Michael, eds., *Inequality and Society*, W.W. Norton & Co., New York.
MAS-IPSP.2005. *Programa de Gobierno – Bolivia digna, soberana y productiva.*. MAS-IPSP, La Paz.
Ministerio de Poder Popular para el Salud & Ministerio de Poder Popular para la Planificación y Desarrollo. 2009. *Plan Nacional de Salud 2009-2013,* Venezuela, Caracas.
Ministerio de Salud y Deportes. 2006. *Plan sectorial de desarrollo 2006-2010*, Ministerio de Salud y Deportes, La Paz.
Ministerio de Salud y Deportes. 2007. *Propuesta para la reforma estructural del sector salud en la Asamblea Constituyente*, Ministerio de Salud y Deportes, La Paz.
Ministerio de Salud y Deportes. 2010. *Plan sectorial de desarrollo 2010-2020 – Hacia la Salud Universal*, Ministerio de Salud y Deportes, La Paz.

Ministerio de Salud y deportes. 2011a. *Proyecto de Ley del Sistema Único de Salud*, Ministerio de Salud y Deportes, La Paz.
Ministerio de Salud y deportes. 2011b. "Congreso concluye con anteproyecto consensuado", *Salud para todos*, no 242, Ministerio de Salud y Deportes, La Paz.
Mesa-Lago, Carmelo. 1978. *Social Security in Latin America – Pressure Groups, Stratification and Inequality*, University of Pittsburgh Press, Pittsburgh.
Mesa-Lago, Carmelo. 2007. *Reassembling social security – A Survey of Pensions and Healthcare Reforms in Latin America*, Oxford University Press, Oxford.
Mkandawire, Thandika. 2005. *Targeting and Universalism in Poverty Reduction*, United Nations Research Institute for Social Development, Geneva.
Navarro, Vicente. 1989. "Why some countries, have national health insurance, others have national health services and the U.S. has neither", *Social Science and Medicine*, vol. 28(9), pp. 887-898.
Orloff, Ann Shola & Skocpol, Theda. 1984. "Why not equal protection? Explaining the politics of public social spending in Britain, 1900-1911 , and the United States, 1880s-1920", *American Sociology Review*, vol. 49(6). pp. 726-5.
Palier, Bruno. 2005. "Ambiguous Agreement, Cumulative Change: French Social Policy in the 1990's" in Mahoney, James & Thelen, Kathleen eds., *Beyond Continuity- Institutional Change in Advanced Political Economies*, Oxford University Press, Oxford.
Pierson, Paul. 2000. "Increasing returns, path dependence, and the study of politics". *The American Political Science Review*, Vol. 94(2), pp 251-267.
Pierson, Paul. 2004. *Politics in Time – History, Institutions and Social Analysis*, Princeton University Press, Princeton.
Picado Chacón, Gustavo & Durán Valverde, Fabio. 2007. *República de Bolivia: Diagnóstico del sistema de seguridad social*, ILO, Lima.
Prieto, A. Lorena & Cid, Camilo. 2010. *Análisis del sector salud de Bolivia*, Banco Interamericano de Desarrollo, Washington D.C.
Rittich, Kerry. 2007. "Social Rights and Social Policy: Transformations on the International Landscape", in Barak-Erez, Daphne and Gross, Aeyal M., eds., *Exploring Social Rights: Between Theory and Practice*. Hart Publishing, Oxford and Portland.
Rothstein, Bo. 2001. "The Universal Welfare State as a Social Dilemma", *Rationality and Society*, vol. 13, pp. 213-233.
Santa Cruz, Gobierno Autónomo de. 2010. *Santa Cruz, Tarija, Beni, Pando y Cochabamba rechazan proyecto de ley gubernamental 'Susalud'*, available at: http://ftp.santacruz.gob.bo/prensa/notas/contenido.php?IdNoticia=1182&IdMenu=901, quoted 2011-09-15.
Skocpol, Theda. 1985. "Bringing the State Back In: Strategies of Analysis in Current Research", in Evans, Peter B. et al eds., *Bringing the State Back In*, Cambridge University Press, Cambrige.
Skocpol, Theda & Amenta, Edwin. 1986. "States and Social Policy", *Annual Review of Sociology*, vol. 12, pp. 131-157.
Stephens, John D. 1979. *The Transition from Capitalism to Socialism*. Macmillan, London.
Tejerina Silva, Herland; De Paepe, Pierre; Soors, Werner; Lanza, Oscar V.; Closon, Marie-Christine; Van Dessel, Patrick & Unger, Jean-Pierre. 2011. "Revisiting health policy and the World Bank in Bolivia", *Global Social Policy*, vol. 11(1), pp. 22-44,
Torres Tovar, Mauricio. 2007. "ALAMES: Organisational Expresion of Socail Medicine in Latin Amreica", *Social Medicine*, vol. 2, nr. 3, pp. 123-130.
UDAPE. 2008. "Gasto público no social, social y en la niñez y adolescencia según función, 2000-2006 (en porcentaje respecto al Gasto Público Total)", *Compendio Estadístico: Inversión Social e Inversión Social en la Niñez y Adolescencia*. UDAPE, La Paz.
UDAPE/UNICEF. 2006. *Evaluación de Impacto de los Seguros de Maternidad y Niñez 1989-2003*, UDAPE & UNICEF, La Paz.

Webber, Jeffrey R. 2011. *From Rebellion to Reform in Bolivia: Class Struggle, Indigenous Liberation, and the Politics of Evo Morales,* Haymarket Books, Chicago.
Weisbrot, Mark; Ray, Rebecca & Johnston, Jake. 2009. *Bolivia: The Economy During the Morales Administration*, Centre for Economic and Policy Research, Washington D.C.
Weyland, Kurt. 2006. *Bounded Rationality And Policy Diffusion – Social Sector Reform in America Latina*, Princeton University Press, Princeton.
WHO. 1978. *Declaration of Alma Ata*, International Conference on Primary Health Care, Alma Ata.
WHO. 2011. "Bolivia Plurinational States of - National Expenditure on Health (Boliviano)", *Global Health Expenditure Database*, available at: http://apps.who.int/nha/database/ChoiceDataExplorerRegime.aspx, quoted 2011-08-19.
World Bank. 1997. *Health, Nutrition, and Population Sector Strategy Paper*, World Bank, Washington, D.C.
World Bank. 2005. *Program Document: Boliva SSPC II*, World Bank, Washington, D.C.
World Bank. 2009. *Estrategia de Asistencia del Banco Mundial al Estado Plurinacional de Bolivia*, World Bank, Washington, D.C.

Interviews

1. Aguilar Álvarez, Reynaldo. 2011. Head of the Public Insurance Unit, Ministry of Health and Sports.
2. Crespo Infantes, Germán Alejandro. 2011. Planning Director, Ministry of Health and Sports.
3. Cuentas, Guillermo. 2011. Former Minister of Health (1997-2002).
4. Executive Committee. 2011. Confederación Nacional de Mujeres Campesinas Indígenas Originarios de Bolivia – Bartolina Sisa, (National Confederation of Indigenous Peasant Women – Bartolina Sisa).
5. Esquivel Velasquez, Adhemar. 2011. Unit for Analysis of Social and Economic Policy (UDAPE).
6. Flores, Margarita. 2011. Head of Public Insurances, Ministry of Health and Sports.
7. Garcia, Benedicta. 2011. Deputy (MAS-IPSP), Social Security and Social Protection Committee, Plurinational Legislative Assembly.
8. Izquierdo, Emigdio. 2011. Secretary of Conflicts, Bolivian Workers' Confederation (COB).
9. Jemio Ortuño, Jorge. 2011. General Director of Health Promotion, Ministry of Health and Sports.
10. Laruta, Carlos Hugo. 2011. Party representative, Unidad Nacional.
11. Maturano Trigo, Martín. 2011. Vice-minister of Health, Ministry of Health and Sports.
12. Oporto Barrozo, Gilda Alcira. 2011. Deputy (MAS-IPSP), Health, Sports and Recreation Committee, Plurinational Legislative Assembly.
13. Paz Nina, Isidro. 2011. Party representative, Movimiento Sin Miedo.
14. Peñaranda España, Carlos M. 2011. General administrator. Chamber of the Pharmaceutical Industry/Bolivian Confederation of Private Enterprises.
15. Pereira Loayza, Nancy Elisabeth. 2011. Executive secretary, Medical Union of La Paz.
16. Quenta, Daniela. 2011. Executive, National Federation of Domestic Workers.

Methodological appendix

When deciding who to interview the starting points have been the theories which are to be tested. The interviewees have mainly been located by the author through their position in organisations and institutions which are of importance to the case. Thus representatives of civil society, especially those representing different sectors of the labour force, have been chosen along with a representative of the employers' organisations and political parties, in line with the power resource approach. Public officials from the Ministry of Health have also been selected bearing in mind both their access to inside information about the policy process and their potential role as autonomous actors in this process as a state-centred approach indicates. Interviews have also been carried out with informants who are chosen on the basis of their general knowledge about the case at hand and whose perspectives are thought to contribute to the understanding of the process of reform (interviews 3 and 5). These latter interviewees have unlike the others been approached after recommendations of initial contacts. The main shortcoming of the final sample is the absence of representatives of international organisations and financial institutions, which could have strengthened the assessment of the processes of policy diffusion. The role of these is instead assed in the other interviews and through the review of written sources.

Below is the interview guides used when conducting the field research in Bolivia. Due to the semi structured approach the time each interview took varied, from half an hour up to almost two hours, with most of them lasting for a little less than an hour. A first set of questions were used when interviewing government officials and other persons with well-informed perspectives on the Bolivian healthcare system and the process of reform. These interviews are thus more of a informant character and includes questions on the design of the reforms. Thereafter follows a set of questions used when interviewing actors with claims towards the healthcare system and are thus more of a respondent character. However, the division of the interviewees in categories of respondents and informants is not clear cut. Clearly, many of those who are best situated to give informed statements on factual matters also have an interest in the process of reform. The questions used when interviewing those perceived primarily as actors are intended both to reveal the actors' views on the healthcare system and the process of reform as well as their interaction with this process. There are accordingly several questions included in the actor interviews which are meant to corroborate information provided from other sources, identify how the respondents have understood the process under study and reveal any potential biases of different sources, together with questions meant to reveal the interests and actions of the actor represented by the respondent.

Interviews with informants and government officials

1. Could you please introduce yourself and tell me about your organisation/institution and how you got to hold your current position?

2. What do you perceive as the primary shortcomings of the Bolivian healthcare system?

3. How will the system of healthcare services be reformed with the new Unified Healthcare System?

4. How will the new Unified Healthcare System be financed?

5. Could you describe the process which has led up to the current proposal for a Unified Healthcare System?

6. Who do you perceive as the main beneficiaries and losers with the policies the Ministry of Health and Sports proposes?

7. What is the origin of the plan to introduce a Unified Healthcare System with universal accesses suggested by the ministry?

8. Why are the proposals for a universal healthcare system launched right now?

9. Which actors have been influential in this process and at which have been the channels these actors have used to exert this influence?

10. At what stage of the political process have these actors been most influential?

11. Why has the introduction of the new policies been delayed?

12. Who have been the primary actors and political forces who have promoted the Unified Healthcare system with universal access which are now being launched by the Ministry of Health and Sports?

13. Has there been any dialog on international level about the design of the Unified Healthcare System, with other governments or with international institutions? When and with who?

14. Has there been a dialog on national or local level with the civil society, social movements or representatives of the institutions which would be affected by the reform? When and with who?

15. What has been the role of local and regional governments?

16. How has the policies in the healthcare sector developed, including the system of public insurance schemes and who have been the primary actors promoting these policies?

Interviews with non-state actors

1. Can you describe your organisation, its' objectives and activities?

2. What do you perceive as the primary shortcomings of the Bolivian healthcare system?

3. Which do you perceive as the reasons for the low coverage in healthcare in Bolivia?

4. Which are your proposals to change or improve the healthcare system?

5. How are you working in order to change the current situation in the health sector and achieve your objectives?

6. Are you familiar with the government's proposal to introduce a unified healthcare system with universal access?

7. What do you think of this proposal, how would you evaluate it?

8. What do you perceive to be the origin of these proposals to introduce a Unified Healthcare System with universal accesses suggested by the ministry?

9. Who are the actors promoting this reform?

10. Who are opposing it?

11. Why are the proposals for a universal healthcare system launched right now?

12. What is the role of the local and regional governments in the healthcare reform?

13. Have you or our organisation participated in any dialog with the government about the Unified Healthcare System?